

COTTONWOOD HEIGHTS

RESOLUTION NO. 2009-38

A RESOLUTION APPROVING ENTRY INTO A PROVIDER AGREEMENT WITH EYEMED VISION CARE FOR VISION INSURANCE

WHEREAS, the city council (the "*Council*") of the city of Cottonwood Heights (the "*City*") met in regular session on 23 June 2009 to consider, among other things, approving a provider agreement (the "*Agreement*") with EyeMed Vision Care ("*EyeMed*") whereunder EyeMed would act as the vision insurance provider for City's employees on the terms and conditions specified in the Agreement; and

WHEREAS, the Council has reviewed the form of the Agreement, a photocopy of which is annexed hereto; and

WHEREAS, after careful consideration, the Council has determined that it is in the best interests of the health, safety and welfare of the citizens of the City to approve the City's entry into the Agreement as proposed;

NOW, THEREFORE, BE IT RESOLVED by the Cottonwood Heights city council that the attached Agreement is hereby approved, and that the City's mayor and recorder are authorized and directed to execute and deliver the Agreement on behalf of the City.

This Resolution, assigned no. 2009-38, shall take effect immediately upon passage.

PASSED AND APPROVED effective 23 June 2009.

COTTONWOOD HEIGHTS CITY COUNCIL



Linda W. Dunlavy
Linda W. Dunlavy, Recorder

By *Kelvyn H. Cullimore, Jr.*
Kelvyn H. Cullimore, Jr., Mayor

VOTING:

Kelvyn H. Cullimore, Jr.	Yea <input checked="" type="checkbox"/>	Nay <input type="checkbox"/>
Gordon M. Thomas	Yea <input checked="" type="checkbox"/>	Nay <input type="checkbox"/>
J. Scott Bracken	Yea <input checked="" type="checkbox"/>	Nay <input type="checkbox"/>
Don J. Antczak	Yea <input checked="" type="checkbox"/>	Nay <input type="checkbox"/>
Bruce T. Jones	Yea <input checked="" type="checkbox"/>	Nay <input type="checkbox"/>

DEPOSITED in the office of the City Recorder this 23rd day of June 2009.

RECORDED this 24 day of June 2009.

WST\CH\524738.1



COTTONWOOD HEIGHTS

Benefit presented is for 07/01/2009 effective date.

Member Copay:

Exam \$10.00
Lens \$25.00

Frequency:

Exam Once per 12 mths
Frame Once per 12 mths
Lenses or Contacts Once per 12 mths

Monthly Fee:

Subscriber Only \$7.24
Subscriber + 1 Dependent \$13.76
Subscriber + Family \$20.20

Rate Contribution Level Definition:
Voluntary (Employer pays less than 25%)

Rate Terms and Conditions:
Benefit presented has a 48-month policy term and rate guarantee.

Pricing includes broker commissions.

Rates are valid based on group domiciled in the state of UT and group size of 10 - 500 eligible employees.

Fees quoted are valid until the stated effective date.

www.eyemedvisioncare.com

Select Exam & Materials - Medium Option BENEFIT DESIGN SUMMARY

EyeMed Vision Care in conjunction with Fidelity Security Life Insurance Company
Vision Care Services

In-Network

Out-of-Network

Member Cost

Member Reimbursement

Exam with Dilation as Necessary:

\$10 Copay

Up to \$35

Contact Lens Fit and Follow Up(Contact lens fit and two follow-up visits are available after comprehensive eye exam):

Standard¹
Premium²

Up to \$40
10% off Retail

N/A
N/A

Frames(any available frame at provider location):

\$0 Copay; \$120 Allowance, 20% off balance over \$120

\$48

Standard Plastic Lenses:

Single Vision

\$25 Copay

Up to \$25

Bifocal

\$25 Copay

Up to \$40

Trifocal

\$25 Copay

Up to \$60

Standard Progressive Lens³

\$25, 80% of charge less \$55 allowance

Up to \$40

Premium Progressive Lens³

\$25, 80% of charge less \$55 allowance

Up to \$40

Lens Options(paid by the member):

UV Treatment

20% off retail price

N/A

Tint (Solid and Gradient)

20% off retail price

N/A

Standard Plastic Scratch Coating

20% off retail price

N/A

Standard Polycarbonate

20% off retail price

N/A

Standard Anti-reflective Coating

20% off retail price

N/A

Other Add-Ons and Services

20% off retail price

N/A

Contact Lenses:(allowance includes materials only)

Conventional

\$135 allowance, 15% off balance over \$135

\$95

Disposable

\$135 allowance, plus balance over \$135

\$95

Medically Necessary

\$0 Copay, Paid-in-Full

\$200

¹ Standard Contact Lens Fitting - spherical clear contact lenses in conventional wear and planned replacement (examples include but not limited to disposable, frequent replacement, etc.)

² Premium Contact Lens Fitting - all lens designs, materials and specialty fittings other than Standard Contact Lenses (examples include toric, multifocal, etc.)

³ Standard/Premium Progressive Lens not covered - fund as a Bifocal Lens

Standard Progressive Lens covered - fund Premium Progressive as a Standard

Additional Value Added Savings

Members will receive a 20% discount on items not covered by the plan at network Providers, which may not be combined with any other discounts or promotional offers, and the discount does not apply to EyeMed Provider's professional services, or contact lenses. Retail prices may vary by location.

Discounts do not apply for benefits provided by other group benefit plans. Allowances are one-time use benefits; no remaining balance. Lost or broken materials are not covered.

Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used.

Members also receive 15% off retail price or 5% off promotional price for Lasik or PRK from the US Laser Network, owned and operated by LCA Vision. Since Lasik or PRK vision correction is an elective procedure, performed by specially trained providers, this discount may not always be available from a provider in your immediate location. For a location near you and the discount authorization please call 1-877-SLASER6.

After initial purchase, replacement contact lenses may be obtained via the internet at substantial savings and mailed directly to the member. Details are available at www.eyemedvisioncare.com. The contact lens benefit allowance is not applicable to this service.

This plan design is offered with the EyeMed Select panel of providers. Minimum 10 enrolled employees required.

Underwriter

Insured plans are underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri, except in New York. Fidelity Security Life Policy number VC-73 and VC-74, form number M-9059.

This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer.

Plan Limitations / Exclusions:

- Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing
- Services provided as a result of any Workers Compensation law
- Aniseikonic lenses
- Services or materials provided by any other group benefit providing for vision care
- Certain frame brands in which the manufacturer imposes a no discount policy

- Corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under plan
- Medical and/or surgical treatment of the eye, eyes, or supporting structures
- Two pair of glasses in lieu of bifocals
- Plano lenses and non-prescription sunglasses (except for 20% discount)
- Some provisions, benefits, exclusions or limitations listed herein may vary by State

If COTTONWOOD HEIGHTS has chosen this benefit and agrees to the administrative services and requirements outlined above, please sign below and return this sheet with your completed application to your EyeMed sales representative.

Area:

CA LINDA W. DUNLAP, RECOVER

X

KELVIN H. CULLEN, Jr., Mayor

Signature



To Serve and Inspire with Excellence

4000 Luxottica Place • Mason, OH 45040

www.eyemedvisioncare.com

Attn:
Leslie

EyeMed Group Application Check List

- ☐ Group Application
- ☐ Signed Plan Design
- ☐ Signed Commission Agreement
- ☐ Enrollment Forms (Or EDI Spreadsheet)
- ☐ Online Registration Form

M. Adam Stulberg
Sales Representative

Office 866.354.5003
Fax 513.492.4232
Email: astulber@eyemedvisioncare.com

EyeMed

VISION CARE

Underwritten by Fidelity Security Life Insurance Company

Net

Policy No.

Application for Vision Care Benefits

I. EMPLOYER INFORMATION

Employer Name: Cottonwood HeightsTax ID #: 202154375

DBA Name (if other than above): _____

Business Address: 1265 E. Fort Union Blvd Ste. 250City: Cottonwood Heights State: UTZip: 84047

Mailing Address (if other than above): _____

City: _____ State: _____

Zip: _____

Principal Contact: Angela White

Title: _____

Phone: 801-944-7021Fax: 801-944-7005E-mail: awhite@cottonwoodheights.utah.govType of Business: ☐ Proprietorship ☐ Corporation ☐ Partnership ☐ Other (Specify): _____

PLEASE NOTE THE FOLLOWING TYPE BUSINESSES REQUIRE PRIOR CARRIER APPROVAL:

☐ MEWA☐ PEO☐ Trust☐ UnionService Area: ☐ National (US, does not include Puerto Rico) ☐ State Specific (list): _____

Billing Contact Name: _____

Phone: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

If you have subsidiaries, affiliated companies, or divisions who use another name and will be covered by this plan, AND require separate billing invoices, please attach the following information on a separate sheet of paper:

-Name, Address, Billing Contact and Phone Number

If any subsidiary or affiliated companies are to be insured or any Employees are working at a location other than the address above, please explain: _____

Will this plan replace any existing coverage? ☒ Yes ☐ No

If "Yes," indicate name and address of existing insurer.

Name: PEHP EyeMedAddress: 500 E 200S.City: Salt Lake CityState: UTZip: 84102Effective date of existing coverage: 7-1-09Termination date of existing coverage: 6-30-09

If "Yes," are any Employees on COBRA continuation?

☐ Yes☒ No

How many? _____

II. PLAN SELECTION

Please refer to the attached proposal page, signed by the client.

Services are provided by EyeMed Vision Care

A-00725

M - 9059

III. PREMIUMSContribution towards premium ☒ Yes ☐ No

Employer's Premium Contribution for:

Employees: 70%Dependents: 70%

Employee's Premium Contribution for:

Employees: 30%Dependents: 30%

Are Employee and Dependent premiums being paid through a Section 125 Plan?

☐ Yes ☐ No

Are Employee and Dependent premiums being collected by payroll deduction?

☒ Yes ☐ No

Premiums shall be at the rates set forth in the Schedule of Premiums, included on the attached proposal page.

IV. ELIGIBILITY INFORMATIONNumber of Employees: 50Number Applying: unknownNumber Dependents: unknownAre Domestic Partners covered under this plan? ☐ Yes ☒ No

Eligibility Reporting Contact (produces the eligibility file):

Angela White

Address (if different from group): _____

City: _____

State: _____

Zip: _____

Phone: _____

Fax: _____

Email: _____

Eligibility Authorization Contact (Benefits Administrator or Third Party Administrator responsible for verifying vision elections for members)

Name: Diversified Insurance

Phone: _____

Days/Hours of Availability: _____

E-mail: _____

PROBATIONARY PERIODFor New Employees: ☐ 30 days ☐ 60 days ☐ 90 days ☐ 180 days☒ Other benefits start date of hireProbationary Period is waived for present Employees: ☒ Yes ☐ No

Number of Employees who have not yet completed the probationary period: _____

V. EFFECTIVE DATE1. This plan will become effective at 12:01 a.m. Standard Time at the employer's address herein, on 7-1, 2009 provided that all of the following have been completed prior to this effective date:

A. This application has been received and accepted by the Company (must be submitted 30 days in advance of the effective date).

B. EyeMed has been furnished a working file of all eligible members, according to the membership layout guidelines. It is understood and agreed that EyeMed may rely on this information to provide services to individuals designated as eligible.

2. This plan will be effective through 10-30, 2009 (12 months) and the premium is based on the information provided.

The Employer hereby makes application to Fidelity Security Life Insurance Company for Vision Care Benefits. The Employer agrees to maintain and furnish any records necessary to administer the plan, and to forward premiums monthly in advance.

The Employer certifies that all the information shown on this application and any attachments are correct and complete and understands that the Insurance Company intends to rely on this information in determining whether or not the enrolling Employees may become insured. It is further understood and agreed that **NO INSURANCE WILL BECOME EFFECTIVE UNTIL APPROVED BY THE INSURANCE COMPANY**; and that no field representative of the Insurance

Company has the authority to modify any conditions of application, or policies, by making any promise or representation. It is understood that the insurance as to any Employee will not become effective on the date insurance should otherwise become effective if he is not at work on such date performing all duties of his occupation and otherwise meets the requirements of the Insurance Company.

Agent:

☒ Signed for the Employer:

KELVIN H. CUMMINS, JR., Manager

LINDA W. OUNLUM, Receptionist

Title: _____

Date: 6/23/09

VI MEMBER ID CARDSGroup will be receiving EyeMed ID cards: ☒ Yes ☐ No

Plan Display Name: Cottonwood Heights

(Company Name as you want it to appear on all other correspondence).

Company Name as you want it to appear on the ID card. (Can only be 30 characters including punctuation, spacing & any code)

Cottonwood Heights

All EyeMed ID cards are mailed directly to employees' home address

**ATTENTION: THE DEPARTMENT OF INSURANCE REQUIRES THAT ONLY
THE BROKER AND/OR GENERAL AGENT WHO SOLD THE PRODUCT AND HOLDS A VALID LIFE
AND HEALTH LICENSE MAY COMPLETE THE CERTIFYING STATEMENT.**

WRITING BROKER'S CERTIFYING STATEMENT

I certify that I have accurately recorded on this application the information supplied by the proposed policyholder(s).

Firm Name (print): Diversified Insurance Group Tax ID Number: 20-4402550

Broker Name (print): Patrick Brown

Address: 136 E. South Temple #2300

City: Salt Lake City State: UT

Zip: 84111

Phone: 801-325-5054

Fax: 801-401-7144

Primary Contact: Leslie Henderson

Secondary Contact: Patrick Brown

Title: Account Manager

Title: Producer

Email: lhenderson@digrisk.com

Email: pbrown@digrisk.com

☒ Broker Signature: _____**WRITING GENERAL AGENT'S CERTIFYING STATEMENT**

I certify that I have accurately recorded on this application the information supplied by the proposed policyholder(s).

Firm Name (print): _____

Tax ID Number: _____

General Agent Name (print): _____

Address: _____

City: _____

State: _____

Zip: _____

Phone: _____

Fax: _____

Primary Contact: _____

Secondary Contact: _____

Title: _____

Title: _____

Email: _____

Email: _____

☒ General Agent's Signature: _____

EyeMed

VISION CARE.

Enrollment/Change Form

Please print and complete **all** sections.

See instructions below.

Underwritten by Fidelity Security Life Insurance Company of
Kansas City, Missouri

EMPLOYER INFORMATION (To be completed by Employer)						
Group Number	Employer Name		Location Code	Division Code	Client Co Code	Effective Date
EMPLOYEE INFORMATION (To be completed by Employee)						
<input type="checkbox"/> ADD <input type="checkbox"/> TERM <input type="checkbox"/> CHG	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Member ID	Last Name (Employee or subscriber)	First Name	M.I.	Date of Birth
Social Security Number		Home Street Address		City/State/Zip		Home Phone ()
FAMILY INFORMATION (Only those eligible to be enrolled. (A) Add (initially), (T) Term, (C) Change (change of name)						
<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (spouse)	First Name	M.I.	Date of Birth	Social Security Number
<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	Date of Birth	Social Security Number
<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	Date of Birth	Social Security Number
<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	Date of Birth	Social Security Number
<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name	M.I.	Date of Birth	Social Security Number
Employee Signature: _____				Date: _____		

Instructions:

Employer name: Legal name of the employer.
Group Number: Provided by EyeMed or EyeMed representative.
Location code: Optional field for employers to track multiple locations.
Effective date: Date set by employer in accordance with EyeMed proposal. Employer also sets effective date for new adds during contract period.

Family Information: List only eligible family members who are enrolling.
 Dependent eligibility is the same as employer's health plan.
(A) Add: Open (group) enrollment or new (individual) enrollment during the contract period.
(T) Terminate: To terminate enrollment.
(C) Change: A change of name, employee address or employee phone.

Once you elect EyeMed vision coverage, you cannot cancel for a 12-month period based upon your enrollment date. Deductions are adjusted according to payroll frequency.

**EyeMed Online Group Management System
Client Account Registration for Member Enrollment/Disenrollment Information
Fixed Fee and Discount Plans**

Client Account Owner	Plan Name	Plan Number
Client Account Owner (enter below)		

The EyeMed Online Group Management System is an administrative tool that enables the Client to register account users to view, edit and maintain member enrollment/disenrollment, protected health information, for the EyeMed vision plan. The Online Group Management System is for the Client's benefit to access member enrollment and disenrollment information.

To register and have access to the EyeMed Online Group Management System, the client must complete the above information and sign below.

The Client is responsible to define one Account Owner for each plan registered for the EyeMed Online Group Management System. The Client Account Owner is the individual designated by the Client to be responsible for assigning and maintaining user roles and responsibilities related to the ability to view, edit and/or maintain member enrollment/disenrollment, protected health information, for the plan. EyeMed will have the responsibility to add and delete Client Account Owners based on written direction received from the Client.

The Client Account Owner will have rights to view and/or maintain member enrollment/disenrollment, protected health information, for the plan. Each Client Account Owner will have rights related to all areas of functionality available via the EyeMed Online Group Management System.

The Client Account Owner will be responsible for registering individuals within the Client's organization as Account Users for a defined plan. Brokers and/or Third Party Administrators involved with the plan may be registered as Account Users if deemed appropriate by the Client Account Owner. Client is responsible for obtaining a Business Associates Agreements if the Client chooses to register third parties such as brokers or third party administrators as Account Users to assist Client Account Owner with health plan operations.

The Account Users have the right to view and/or maintain member enrollment/disenrollment, protected health information, for the plan. Each Client Account User will have defined rights related to the specific areas of functionality available via the EyeMed Online Group Management System. The Client Account Owner will have the responsibility to add and delete users as required by the client.

As signatory for the client, I certify that the above information is correct and complete. I understand that EyeMed Vision Care intends to rely on this information and will grant the individuals listed above as Client Account Owners with the ability to view and maintain member enrollment/disenrollment, protected health information, related to the plans listed above. The Client has approved for this individual to be responsible for assigning and maintaining Account User roles and responsibilities related to the ability to view and/or maintain member enrollment/disenrollment, protected health information, for the plan as appropriate. Account User roles and responsibilities will be assigned appropriately based on the individual's role within the client's organization. Client acknowledges that EyeMed reserves all rights to audit the use of the Online Group Management System by client's representatives and discontinue, in its sole discretion, any Client Account Owner or Account Users at any time, with or without notice.

Name: _____

Company Name: _____

Title: _____

Date: _____

Signature: _____

EyeMed Online Group Management System Terms and Definitions

Client:

The Client is the Plan Sponsor or entity that has vision benefits with EyeMed. The EyeMed Online Group Management System Client Account Registration Form and all future notification of changes to defined Client Account Owners must be signed and submitted by the person entitled to contract on behalf of the entity.

Client Account Owner:

Individual designated by the Client to be responsible for assigning and maintaining user roles and responsibilities related to the ability to view and/or maintain member enrollment/disenrollment, protected health information, for the plan. EyeMed will have the responsibility to add and delete Client Account Owners based on written direction received from the Client.

Client Account Owner will be responsible for registering individuals within the Client's organization or third party individuals who have been granted rights to view and/or maintain member enrollment/disenrollment, protected health information, related to the defined plan. The Owner may register brokers and/or Third Party Administrators involved with the plan as Account Users if appropriate.

Account User:

Individual designated by the Client Account Owner to have the right to view and/or maintain member enrollment/disenrollment, protected health information, for the plan. Each Account User will have defined rights related to the specific areas of functionality available via the EyeMed Online Group Management System. The Client Account Owner will have the responsibility to add and delete users as required by the client.

Functionality Available

Member Maintenance

Maintain Enrollment/Disenrollment Data: Access to enrollment/disenrollment, protected health information, of the members. User has the ability to add, change or delete member enrollment/disenrollment information for the defined plan.

View Enrollment/Disenrollment Data: Access to enrollment/disenrollment, protected health information, of the members. User can view all member enrollment information for the defined plan.

Reports

View Premium Invoice Data: Access to enrollment/disenrollment, protected health information, of the members. User can view monthly premium invoice for the plan and has ability to view or download monthly roster of enrolled members.

Member Search

View Member Information and/order Replacement ID Card: Access to enrollment/disenrollment, protected health information, of the members. User can view member information, order replacement ID card, view list of related members and view summary of member benefits.